

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155156		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/07/2013	
NAME OF PROVIDER OR SUPPLIER ARBORS AT MICHIGAN CITY				STREET ADDRESS, CITY, STATE, ZIP CODE 1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00138634.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey.</p> <p>Complaint IN00138634 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: October 31, November 1, 4, 5, 6, and 7, 2013</p> <p>Facility number: 000076 Provider number: 155156 AIM number: 100271060</p> <p>Survey team: Yolanda Love, RN-TC (October 31, November 1, 4, 5, and 7, 2013) Cynthia Stramel, RN (October 31, November 1, 4, 5, and 7, 2013) Lara Richards, RN Heather Tuttle, RN</p> <p>Census bed type: SNF 31 SNF/NF 119 Total 150</p> <p>Census payor type: Medicare 37 Medicaid 94 Other 19 Total 150</p> <p>Arbors At Michigan City was found to be in compliance with 42 CFR Part 483, Subpart B and</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155156	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/07/2013
NAME OF PROVIDER OR SUPPLIER ARBORS AT MICHIGAN CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	Continued From page 1 410 IAC 16.2 in regard to the Investigation of Complaint IN00138634. Quality review completed on November 14, 2013, by Janelyn Kulik, RN.	F 000			